



DEFENSE LOGISTICS AGENCY  
HEADQUARTERS  
8725 JOHN J. KINGMAN ROAD  
FORT BELVOIR, VIRGINIA 22060-6221

IN REPLY  
REFER TO

DES-E

JUL 13 2005

MEMORANDUM FOR ALL DLA EMPLOYEES

SUBJECT: Federal Recordkeeping Changes for Injuries and Illnesses

On January 1, 2005, requirements for reporting and recording Federal injuries and illnesses changed. The Occupational Safety and Health Administration (OSHA) issued the final rule on November 26, 2004, amending Federal recordkeeping requirements. The changes directed by the final rule will affect any Defense Logistics Agency (DLA) employee who sustains a work-related injury or illness. DLA is required to maintain appropriate mishap records and comply with requirements of the amended rule. Significant changes of the rule expand the number of accident data elements required, adds non-appropriated fund and some contractor employee reporting, and makes Federal requirements identical to the private sector.

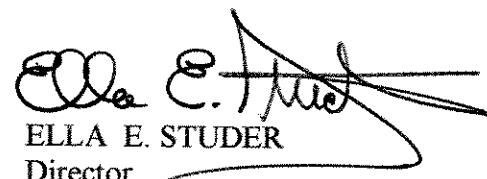
DLA employees, including full-time, part-time, seasonal, non-appropriated fund, and contractors, must report all work-related injuries or illnesses to their supervisors as soon as possible but no later than 1 day after occurrence. Amended recordkeeping changes require contractor employees who are supervised on a day-to-day basis by DLA to be included in our mishap records. New requirements mandate that employees who experience a work-related injury or illness provide their home address along with the name of the physician providing medical treatment (if any). Please note, this information is necessary to comply with OSHA's new rule; and the privacy of all employees will always be maintained.

Supervisors of employees who sustain work-related injuries or illnesses must notify their local safety and health offices by forwarding a completed Supervisory Mishap Report Form, DLA Form 1591, within 1 working day of receiving information. The revised form incorporates requirements of the amended Federal recordkeeping rule and is available at the DLA Forms Web site: <http://www.dla.mil/dss/forms> and through the DLA eWorkplace Portal.

The recordkeeping change is significant. Currently, DLA projected injury/illness reduction goals are not being met. Accurate recordkeeping of all injuries and illnesses is crucial for data analysis, and is the basis for Safety and Health Program improvement and the development of preventive countermeasures. All managers, supervisors, and employees are asked to help make this transition as smooth as possible by complying with the mandated



requirements of the amended rule. It is requested that this memorandum be given wide dissemination. Your local Safety and Health Offices are available to assist you with questions about recordkeeping changes or completion of the new report form. For additional assistance, please contact the project officer, Ms. Joyce Bellamy, of the Headquarters DLA Enterprise Support, Environment and Safety Office at (703) 767-6239 or DSN at 427-6239.



ELLA E. STUDER  
Director  
DLA Enterprise Support Services

Attachment

SUPERVISORY MISHAP REPORT		1. MISHAP DATE (MM/DD/YYYY):	2. MISHAP TIME (24 Hour):	3. ORGANIZATION CODE:														
<input type="checkbox"/> Injury	<input type="checkbox"/> Illness	<input type="checkbox"/> Damaged Equipment or Property	<input type="checkbox"/> Damaged Motor Vehicle															
4. MISHAP CASE CLASSIFICATION (Check appropriate classification) <table> <tr> <td><input type="checkbox"/> Same Day Clinic Visit or No Treatment</td> <td><input type="checkbox"/> Medical Expenses Only</td> </tr> <tr> <td><input type="checkbox"/> Two or More Clinic Visits on Non-duty Time</td> <td><input type="checkbox"/> Clinic Visit(s) at Work After Injury/Illness Date</td> </tr> <tr> <td><input type="checkbox"/> Lost Time (enter number of days)</td> <td><input type="checkbox"/> Fatality (Date of Death _____)</td> </tr> </table>					<input type="checkbox"/> Same Day Clinic Visit or No Treatment	<input type="checkbox"/> Medical Expenses Only	<input type="checkbox"/> Two or More Clinic Visits on Non-duty Time	<input type="checkbox"/> Clinic Visit(s) at Work After Injury/Illness Date	<input type="checkbox"/> Lost Time (enter number of days)	<input type="checkbox"/> Fatality (Date of Death _____)								
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5. PRIMARY LOCATION:		On TDY: <input type="checkbox"/> Yes <input type="checkbox"/> No	6. SECONDARY LOCATION															
7. LAST NAME:		8. FIRST NAME:	9. INITIAL	10. SEX:														
11. EMPLOYEE SSN/ENN:		12. JOB TITLE:																
13. HOME ADDRESS OF EMPLOYEE:		14. CITY:	15. STATE:	16. COUNTRY:														
18. TIME EMPLOYEE BEGAN WORK:		19. WAS EMPLOYEE WORKING OVERTIME:	20. PERSONNEL CLASS:															
		<input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> Civilian Employee <input type="checkbox"/> Contractor Employee <input type="checkbox"/> Foreign National Employee <input type="checkbox"/> Other:	<input type="checkbox"/> Military (Title) _____ <input type="checkbox"/> Non-Appropriated Fund <input type="checkbox"/> Direct Hire <input type="checkbox"/> Indirect Hire														
21. WHAT WAS THE SINGLE MOST SEVERE INJURY/ILLNESS TO THIS EMPLOYEE:		22. WHAT PART OF THE BODY RECEIVED THE MOST SEVERE INJURY:																
<input type="checkbox"/> Amputation <input type="checkbox"/> Bruises <input type="checkbox"/> Burn, Chemical <input type="checkbox"/> Burn, Thermal <input type="checkbox"/> Concussion <input type="checkbox"/> Other:		<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomin <input type="checkbox"/> Exposure <table> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Leg</td> </tr> <tr> <td><input type="checkbox"/> Eye(s)</td> <td><input type="checkbox"/> Shoulder(s)</td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Hand/Finger</td> <td><input type="checkbox"/> Foot/Toe</td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td><input type="checkbox"/> Internal</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Part of Body <input type="checkbox"/> Right <input type="checkbox"/> Left</td> </tr> </table>			<input type="checkbox"/> Back	<input type="checkbox"/> Leg	<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Shoulder(s)	<input type="checkbox"/> Arm	<input type="checkbox"/> Knee	<input type="checkbox"/> Wrist	<input type="checkbox"/> Ankle	<input type="checkbox"/> Hand/Finger	<input type="checkbox"/> Foot/Toe	<input type="checkbox"/> Other:	<input type="checkbox"/> Internal	<input type="checkbox"/> Part of Body <input type="checkbox"/> Right <input type="checkbox"/> Left	
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<input type="checkbox"/> Part of Body <input type="checkbox"/> Right <input type="checkbox"/> Left																		
23. NAME OF PHYSICIAN / HEALTH CARE PROFESSIONAL PROVIDING TREATMENT:																		
24. NAME OF COMPANY PROVIDING MEDICAL TREATMENT:																		
25. ADDRESS OF MEDICAL PROVIDER:		26. CITY:	27. STATE:	28. COUNTRY														
				29. ZIP CODE														

30. Was employee treated in an Emergency Room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
31. Was employee hospitalized overnight as an in-patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
32. Did this mishap result in the employee being placed on restricted duty?  (Restricted duty means that the employee was unable to perform all the tasks that they normally do at least once a week)	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, for how many days: _____				
33. Did this mishap result in the employee being transferred to another position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, for how many days: _____				
34. Date employee stopped work or first became aware of illness (mmddyyyy):  _____						
35. WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED:						
36. MISHAP DESCRIPTION: Describe what happened, how and why. Include the names of witnesses to this accident. If the accident was not reported to the first line supervisor on the same day that it happened, explain why. If any motorized material handling equipment was involved in this accident, identify the type of equipment involved and explain how it was involved.						
37. ESTIMATED COST OF DAMAGES:	38. IF CONTRACTOR CAUSED MISHAP, PROVIDE CONTRACTOR'S COMPANY NAME AND ADDRESS:  _____					
INFORMATION ON VEHICLE(S) AND EQUIPMENT THAT WERE INVOLVED IN THE ACCIDENT						
39. Year	40. Make	41. Model	42. State & License #	43. Vehicle Identification/Serial Number	44. Licensed Driver?	45. Were Seatbelts Used?
#1					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
#2					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SHIRS Case #	SHIRS Case # _____							
OSHA Log # (To be completed by Safety and Health Office)	OSHA Log # _____							
<b>SUPERVISORY REVIEW</b>								
46. CORRECTIVE ACTIONS - Describe what actions have been taken to prevent similar accidents happening to other employees. If the hazard has not yet been corrected, describe what interim actions have been taken to prevent further injuries to employees and the estimated date the hazard(s) will be corrected. Was this accident reported to you or your designated representative on the same day that it happened? If no, why not?								
47. NAME AND SIGNATURE:								
<table border="1" style="width: 100%;"> <tr> <td style="width: 33%;">48. ORGANIZATION:</td> <td style="width: 33%;">49. TELEPHONE (cmcl &amp; DSN):</td> <td style="width: 34%;">50. DATE (mmddyyyy):</td> </tr> <tr> <td colspan="3"><b>SAFETY AND HEALTH REVIEW</b></td> </tr> </table>			48. ORGANIZATION:	49. TELEPHONE (cmcl & DSN):	50. DATE (mmddyyyy):	<b>SAFETY AND HEALTH REVIEW</b>		
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51. SAFETY AND HEALTH OFFICE/MONITOR'S COMMENTS:								
52. NAME AND SIGNATURE:								
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57. NAME AND SIGNATURE:								
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DLA Form 1691, MAY 2005								
PDF (DLA)								

#### **PRIVACY ACT STATEMENT**

<b>Purpose:</b>	Information is collected to comply with regulatory reporting requirements. Details about the accident site will be used to identify and correct known or potential hazards and to formulate improved accident prevention programs. The data, with all personal identifiers removed, may also be used to prepare statistical reports.
<b>Authority:</b>	10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 29 U.S.C. 651 et seq., The Occupational Safety and Health Act of 1970 (OSHA); E.O. 9397 (SSN); E.O. 12196, Occupational Safety and Health Programs for Federal Employees; and 29 CFR 1960, Subpart I, Record keeping and Reporting Requirements for Federal Occupational Safety and Health Programs.
<b>Routine Uses:</b>	Data may be disclosed to the Department of Labor to comply with reporting requirements. Data may also be disclosed for any of the DoD Blanket Routine Uses (available at <a href="http://www.defenselink.mil/privacy/notices/blanket-uses.html">http://www.defenselink.mil/privacy/notices/blanket-uses.html</a> )

**Disclosure is Voluntary.** However, failure to provide the requested data may result in our inability to comply with reporting requirements or to identify and correct workplace hazards.

**DLA Privacy Act System Notice S 600.30** (available at <http://www.defenselink.mil/privacy/notices/dla/S600-30.html>) applies to this collection.

#### **INSTRUCTIONAL NOTES**

**Block 4** - If the classification of the mishap changes after report submission it is the supervisor/manager's responsibility to notify the DLA Safety and Health Manager to which the report is submitted, e.g. Same Day Clinic Visit or No Treatment to Lost Time, etc.

**Block 11** - FNN is Foreign National Number. This is the local national employee number provided to foreign national employees.

**Blocks 15 & 27** - AF Europe is defined as Armed Forces Europe and AP Pacific is the Armed Forces Pacific.

**Block 20** - Contractor - There are different types of contractors, i.e. Those obtained under a procurement contract; those performing temporary services, maintenance, repair, etc.; sales contractors, etc. But those contractor employee mishaps reported on the DLA Form 1591 are for contract employees supervised on a day-to-day basis. OSHA Compliance Directive CPL 2-0.131, Frequently Asked Questions # 31-1 defines "supervised" as "Day-to-day supervision occurs when in addition to specifying the output, product or result to be accomplished by the person's work, the employer supervises the details, means, methods and processes by which the work is to be accomplished."

**Block 21** - Describe the extent of injury/illness in Block 36.

**ADDITIONAL NOTES:**